

SECTION 1915(c) WAIVER FORMAT

1. The State of Alaska requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority

This is a request for a model waiver.

a. Yes

b. X No

If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one):

a. 3 years (initial waiver)

b. X 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. _____ Nursing facility (NF)

b. X Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

c. _____ Hospital

d. _____ NF (served in hospital)

e._____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. _____ aged (age 65 and older)

b. disabled

- c. _____ aged and disabled
- d. _____ mentally retarded
- e. _____ developmentally disabled
- f. X mentally retarded and developmentally disabled
- g. _____ chronically mentally ill
4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):
- a. _____ Waiver services are limited to the following age groups (specify):
- b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. _____ Other criteria. (Specify):
- e. _____ Not applicable.
5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.
- a. _____ Yes b. X No
7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
- a. _____ Yes b. _____ No c. X N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. Yes

b. X No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. Yes

b. X No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. X Case management

b. Homemaker

c. Home health aide services

d. Personal care services

e. X Respite care

f. Adult day health

g. X Habilitation

 X Residential habilitation

 X Day habilitation

 Prevocational services

- ☒ Supported employment services
- ☒ Educational services
- h. ☒ Environmental accessibility adaptations
- i. _____ Skilled nursing
- j. ☒ Transportation
- k. ☒ Specialized medical equipment and supplies
- l. ☒ Chore services
- m. _____ Personal Emergency Response Systems
- n. _____ Companion services
- o. _____ Private duty nursing
- p. _____ Family training
- q. _____ Attendant care
- r. _____ Adult Residential Care
- _____ Adult foster care
- _____ Assisted living
- s. _____ Extended State plan services (Check all that apply):
- _____ Physician services
- _____ Home health care services
- _____ Physical therapy services
- _____ Occupational therapy services
- _____ Speech, hearing and language services
- _____ Prescribed drugs
- _____ Other (specify):

- t. X Other services (specify):
- 1) Meals Services.
 - 2) Intensive Active Treatment/Therapies.
 - 3) Specialized private duty nursing
- u. _____ The following services will be provided to individuals with chronic mental illness:
- _____ Day treatment/Partial hospitalization
 - _____ Psychosocial rehabilitation
 - _____ Clinic services (whether or not furnished in a facility)
12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a. X When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. _____ Meals furnished as part of a program of adult day health services.
 - c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
 - b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
 - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
 - d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
 - e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request

under the State plan that would have been made in that fiscal year had the waiver not been granted.

- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of

services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of July 1, 2001 is requested.
20. The State contact person for this request is Jon Sherwood, MAA IV, who can be reached by telephone at (907) 465-3355.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____
Print Name: Karen Perdue
Title: Commisioner, Department of Health and Social Services
Date: July 24, 2001

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

_____ The waiver will be operated by the _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

 X The waiver will be operated by The Division of Mental Health and Development Disabilities, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. _____ Case Management

_____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. ___ Yes

2. ___ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. ___ Yes

2. ___ No

___ X Other Service Definition (Specify):

Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services.

In Alaska, Case Management is referred to as Care Coordination.

Care Coordinators shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

Care Coordinators shall initiate and oversee the process of reviewing plans of care at such intervals as are specified in Appendices C & D of this request.

Within the context of HCB waiver services care coordination may include the following functions:

Evaluation and/or reevaluation of the need for specific waiver services, development and/or review of the plan of care, coordination of multiple services and/or providers, monitoring of quality of care, review of medical necessity of waiver services.

b. _____ Homemaker:

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):

c. _____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

d. _____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

☐ Payment will not be made for personal care services furnished by a member of the individual's family.

☐ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

☐ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

☐ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

☐ A registered nurse, licensed to practice nursing in the State.

☐ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

☐ Case managers

☐ Other (Specify):

3. Frequency or intensity of supervision (Check one):

☐ As indicated in the plan of care

☐ Other (Specify):

4. Relationship to State plan services (Check one):

☐ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

e. X Respite care:

_____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

 X Other service definition (Specify):

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Voucher services for respite: individual voucher respite providers must meet the certification standards for hourly and overnight respite service providers in Appendix B-2.

Due to the remoteness of most Alaskan communities, the labor pool is restricted to individuals living in the immediate area. Furthermore, provider agencies are concentrated in larger towns and cities, thus making it difficult or impossible to deliver respite services in traditional manners. Therefore, offering respite care under a voucher system is an option that may be selected. Voucher services will empower families by giving them direct control over how and when the services are provided and will enable closer scrutiny of the quality of those services. Voucher respite care may be provided only if approved in the recipient's plan of care. Services under this option will be administered as follows:

1. The family will select and train an individual to render respite services.
2. The family signs a letter of agreement with the Qualified HCB agency acknowledging responsibility for compliance with waiver caregiver qualifications (See Appendix B-2) and Internal Revenue Service laws.

3. The provider agency issues coupons to the family based on the number of hours of service at the rate approved in the plan of care and prior authorized on the MMIS. Coupons may be issued monthly or quarterly. The coupon includes a line for the family's signature stating that the respite worker meets qualifications defined in the waiver.
4. When the service is rendered, the family notifies the provider of the dates of service and hours of respite utilized, and the family's satisfaction with the services.
5. The coupon is submitted to the Qualified HCB agency for payment of services rendered.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

- ☒ Individual's home or place of residence
- ☒ Licensed Foster home (Licensed by DFYS or DMHDD Foster home or Assisted Living home)
- ☒ Medicaid certified Hospital
- ☒ Medicaid certified NF
- ☐ Medicaid certified ICF/MR
- ☒ Group home (Licensed by DMHDD as an Assisted Living home)
- ☒ Licensed respite care facility (Licensed by DFYS or DMHDD Foster home or Assisted Living home)
- ☐ Other community care residential facility approved by the State that is not a private residence (Specify type): Licensed Assisted Living Home

f. _____ Adult day health:

- ☐ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen"

(3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. ☐ Yes

2. ☐ No

☐ Other service definition (Specify):

g. ☒ Habilitation:

☒ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

☒ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

☒ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition,

day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

____ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

____ Individuals will not be compensated for prevocational services.

____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

 X Educational services, which consist of special education and services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

 X Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons

without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. X Yes

2. No

 Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations: (Alaska regulations refer to this service as "Environmental Modifications")

 Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home,

and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

- x Other service definition (Specify): Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Each environmental modification must have a specific adaptive purpose that provides accessibility and safety. The footprint of the existing structure may not be expanded by an environmental modification.

i. _____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify): _____

j. X Transportation:

 X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

 Other service definition (Specify): _____

k. X Specialized Medical Equipment and Supplies:

 X Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

 Other service definition (Specify): _____

l. X Chore services:

 X Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

 Other service definition (Specify): _____

m. _____ Personal Emergency Response Systems (PERS)

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify): _____

n. _____ Adult companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify): _____

o. _____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (Specify): _____

p. _____ Family training:

_____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

_____ Other service definition (Specify): _____

q. _____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided In State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (Specify): _____

_____ Other service definition (Specify): _____

r. _____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed____). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State

law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- ☐ Home health care
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Medication administration
- ☐ Intermittent skilled nursing services
- ☐ Transportation specified in the plan of care
- ☐ Periodic nursing evaluations

_____ Other (Specify): _____

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

_____ Other service definition (Specify): _____

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

1) Meal Services: Hot or other appropriate meals which each meet at least one-third of the daily Recommended Dietary Allowance, served to recipients in their homes or day program sites that are necessary to prevent institutionalization. Meals shall not constitute a "full nutritional regimen".

2) Specialized Private Duty Nursing: Services consist of individual and continuous care or part time or intermittent care provided by licensed nurses within the scope of the State's Nurse Practice Act. The intermittent, part time care may offer assessment, monitoring and patient education. The nurse will develop a nursing plan of care, which supports the client's waiver plan of care. These services are provided to an individual at home. Specialized Private Duty Nursing Services are tailored to the specific needs of a particular client and are necessary to prevent institutionalization.

3) Intensive Active Treatment/Therapies: The provision of a treatment or therapy provided by a professional which is oriented to a client-specific problem. These time-limited interventions are designed to address a family problem, or a personal, social, behavioral, mental or substance abuse disorder in order to maintain or improve effective functioning. Intensive active treatment services are determined necessary when intervention requires precision and knowledge possessed only by specific disciplines, and specially trained professionals. Services may be utilized when an individual needs intervention to decelerate regression of behaviors; the recipient requires rapid skill development and acquisition; or the service is necessary to prevent institutionalization.

t. _____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

_____ Prescribed drugs

_____ Other State plan services (Specify):

u. _____ Services for individuals with chronic mental illness, consisting of (Check one):

_____ Day treatment or other partial hospitalization services (Check one):

_____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,

- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify): _____

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,

c. supported employment services, and

d. room and board.

_____ Other service definition (Specify): _____

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations

(Specify) _____

APPENDIX B-2**PROVIDER QUALIFICATIONS****A. LICENSURE AND CERTIFICATION CHART**

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Qualified individuals may become certified as a Care Coordination and/or HCB Agency.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	Other Standard
Care Coordination	DMHDD HCB Agency or DMHDD CC Agency		Certified by DMHDD under 7AAC 43.1090	
Day Habilitation	HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Supported Employment Services	DMHDD HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Intensive Active Treatment Therapies	HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Chore	HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Specialized Medical Equipment and supplies	Medical Supply vendor	Alaska business license		
Environmental Modifications	HCB Agency Licensed Contractor	Contractors licensed under 12 AAC 21.010- 21.990	Certified by DMHDD under 7AAC 43.1090	

SERVICE	PROVIDER	LICENSE	CERTIFICATION	Other Standard
Meals	ACoA Grantee funded to provide meals or, Certified school lunch programs		DEC Certification 18 AAC31 Department of Education 42 CFR 440.180 (b)	
Specialized Private Duty Nursing	HCB Agency		Certified by DSS under 7 AAC 43.1090	Licensed Medicare Home Health Agency or Hospice agency.
Transportation	HCB Agency	Alaska State Driver's License	Certified by DMHDD under 7AAC 43.1090	
Residential Habilitation				
Residential Habilitation provided in consumer's home	DMHDD HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Residential Habilitation provided in an out of home placement	DMHDD HCB Agency		Certified HCB Agency under 7AAC 43.1090	
Respite				
Hourly respite (including hourly voucher respite)	HCB Agency		Certified by DMHDD under 7AAC 43.1090	
Out of home daily respite (including respite agencies and out of home voucher respite)	HCB Agency hospital or nursing home	Licensed hospital or nursing home,	Certified by DMHDD under 7AAC 43.1090	

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- ☐ Home and community-based services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- ☒ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

SECTION 1915(c) WAIVER FORMAT**APPENDIX C-Eligibility and Post-Eligibility****Appendix C-1--Eligibility****MEDICAID ELIGIBILITY GROUPS SERVED**

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. x Low income families with children as described in section 1931 of the Social Security Act.
2. x SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. x Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. x **The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).**

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

 x A. Yes B. No

Check one:

- a. x The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b.____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)____ A special income level equal to:

____ 300% of the SSI Federal benefit (FBR)

____% of FBR, which is lower than 300% (42 CFR 435.236)

\$____ which is lower than 300%

(2)____ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)____ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4)____ Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5)____ Aged and disabled who have income at:

a.____ 100% of the FPL

b.____% which is lower than 100%.

(6)____ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. x Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

See attachments to Appendix C: Categories of Medicaid Eligibility

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES-- ' 435.726 and ' 435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY-- '1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. x **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

- A. 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

- a. Allowances for the needs of the

1. individual: (Check one):

- A. x The following standard included under the State plan (check one):

- (1) SSI

- (2)___ Medically needy

- (3) x The special income level for the institutionalized

- (4)___ The following percent of the Federal poverty level):___%

- (5)____ Other (specify): _____

- B.____ The following dollar amount: \$_____*

* If this amount changes, this item will be revised.

- C.____ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

- A. SSI standard

- ### B. Optional State supplement standard

- C.____ Medically needy income standard

- D.____ The following dollar amount:

\$ _____ *

* If this amount changes, this item will be revised.

E.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

F.____ The amount is determined using the following formula:

G. x Not applicable (N/A)

3. Family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount:
\$ _____ *

*If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

E.____ The amount is determined using the following formula:

F.____ Other

G. x Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

Post Eligibility
REGULAR POST ELIGIBILITY

1.(b)____**209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.____ The following standard included under the State plan (check one):

(1)____ SSI

(2)____ Medically needy

(3)____ The special income
level for the institutionalized

(4)____ The following percentage of
the Federal poverty level:____%

(5)____ Other (specify):

B.____ The following dollar amount:
\$____*

* If this amount changes, this item will be revised.

C.____ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.____ The following standard under 42 CFR 435.121:

B.____ The medically needy income standard_____;

C.____ The following dollar amount: \$_____*

* If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: _____% of

E.____ The following formula is used to determine the amount:

F.____ Not applicable (N/A)

3. family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount:
\$_____*

* If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____standard.

E.____ The following formula is used to determine the amount:

F.____ Other

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

Post Eligibility

SPOUSAL POST ELIGIBILITY

2. x The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a) SSI Standard

(b)___ Medically Needy Standard

(c) x The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:
____%

(e)___ The following dollar amount
\$___**

****If this amount changes, this item will be revised.**

(f) The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

Mental Retardation and Developmental Disabilities		
Category	Social Security Laws	Federal Regs
TITLE IV-E Adoption and Foster Care Children	1902(a)(10)(A)(i)(I)	42 CFR 435.145
Post-Partum	1902(e)(5) and (6)	
NewBorn	1902(a)(10)(A)(i)(III) 1902(e)(4) 1903(l)(1)(B)	42 CFR 435.117
Pregnant Women	1902(e)(6) 1902(a)(10)(A)(i)(III) 1902(l)(1)(A)	42 CFR 435.116 42 CFR 435.170
Denali KidCare (poverty level children CHIP expansion)	1902(a)(10)(A)(i)(VI), (VII), (III) 1902(1)(C) and (D)	42 CFR 457.70
Transitional Medicaid	1902(a)(10)(ii)(XIV)	42 CFR 435.112
4-month Post Medicaid	1902(a)(10)(A)(i)(I) 1931	42 CFR 435.115(f)
Individuals eligible for AFDC except for 1972 20% increase in OASDI payments	None	42 CFR 435.114
Individuals eligible for Medicaid in 1973	None	42 CFR 435.131 42 CFR 435.132 42 CFR 435.133
Individuals eligible for SSI/APA except for 1972 20% increase in OASDI payments	1634(C)	42 CFR 435.134
Children who were receiving SSI on August 22, 1996 and lost SSI because of the change in the definition of disability for children	1634(e)	
Individuals eligible for AFDC or SSI if not in a medical institution	1902(a)(10)(ii)(IV)	42 CFR 435.211
Retroactive Medicaid	1902(a)(34) 1905(a)	
Breast & Cervical Cancer	1902(a)	
Under 21	1902(a)(10)(A)(ii) 1905(a)(i)	42 CFR 435.222
State Only adoption assistance	1902(a)(10)(A)(ii)(VIII)	42 CFR 435.227
Working Disabled Medicaid Buy-In	1902(a)(10)(A)(ii)(XIII) 1905(s)	None
Disabled Children at Home (TEFRA)	1902(e)(3) 1915(c)(10)	42 CFR Part 435 Subpart G and F
Disabled Widow(er)s	1634(b)	42 CFR 435.137 42 CFR 435.138
SSI "Disabled Adult Children"	1634(c)	42 CFR 435.122
Ineligible for SSI or APA because of Requirements prohibited by Medicaid	None	42 CFR 435.122
QDWI	1902(a)(10)(E)(ii) 1905(s)	

APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

 x Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other (Specify):

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

- ☐ Every 3 months
☐ Every 6 months
☒ Every 12 months
☐ Other: _____

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

☒ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

☐ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

- ☐ Physician (M.D. or D.O.)
☐ Registered Nurse, licensed in the State
☐ Licensed Social Worker
☐ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
☐ Other (Specify): _____

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

- ☒ "Tickler" file
☒ Edits in computer system
☒ Component part of case management
☐ Other (Specify): _____

The Inventory for Client and Agency Planning (ICAP) is an assessment tool used as part of the Level of Care determination process. The ICAP is privately owned and protected under copyright. For more information on the ICAP visit their website at:

<http://www.isd.net/bhill/icap.htm>

Or contact Barbara Knapp
Division of Medical Assistance 907-465-3358

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

☐ By the Medicaid agency in its central office

☐ By the Medicaid agency in district/local offices

☒ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

☒ By the case managers

☒ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

☐ By service providers

☐ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

☒ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

☐ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

ICF/MR Level of Care Determination State of Alaska – Division of Mental Health and Developmental Disabilities

Authority: 42 CFR 435.1009; 42 CFR 483.430; 42 CFR 483.440; State Medicaid Manual 4442.5; 7 AAC 43.300; 7 AAC 43.310; 7 AAC 43.1030

Name:

DOB:

Medicaid #: 06

Date of qualifying diagnosis evaluation:

Client's age at ICAP:

SSN:

By Whom:

ICAP Scores DQ

SS

BI Domain

Is this LOC based on new information?

☐ NO

☐ YES - Attach back-up information on each new diagnosis, name of diagnostician, credentials and phone number.

1. Individual has a severe, chronic disability that meets one (1) of the five (5) following conditions:

42 CFR 435.1009; 7 AAC 43.300; 7 AAC 43.1030

☐ Mental Retardation:

Individual must experience an I.Q. of less than 70 (plus or minus 5 points) as determined by an individual, standardized psychological evaluation (DSM-IV). The mental retardation condition must have originated before the age of 22 years and must constitute a substantial disability to the individual's ability to function in society, as evidenced by:

- a) if less than 7 years old, an ICAP Developmental Quotient (Age Equivalent/Chronological Age) of 50 or less,
- b) if 7-17 years old, an ICAP Service Score of 70 or less, or
- c) if age 18 or older, ICAP Broad Independence Domain Score of 514 or less.

☐ Other Mental Retardation related condition:

A condition other than mental illness, psychiatric impairment, serious emotional or behavioral disturbance found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning and adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22; diagnosed by a licensed physician, is likely to continue indefinitely, and:

- a) if less than 7 years old, an ICAP Developmental Quotient (Age Equivalent/Chronological Age) of 50 or less,
- b) if 7-17 years old, an ICAP Service Score of 70 or less, or
- c) if age 18 or older, ICAP Broad Independence Domain Score of 514 or less.

☐ Cerebral Palsy:

Individual must have been diagnosed with cerebral palsy prior to 22 years of age by a licensed physician. A deficit in intellectual ability need not be present, but the cerebral palsy condition must result in a substantial disability that is likely to continue indefinitely and affects the person's ability to function normally in society, as evidenced by:

- a) if less than 7 years old, an ICAP Developmental Quotient (Age Equivalent/Chronological Age) of 50 or less,
- b) if 7-17 years old, an ICAP Service Score of 70 or less, or
- c) if age 18 or older, ICAP Broad Independence Domain Score of 514 or less.

☐ Epilepsy:

Manifested by age 22 and diagnosed by a licensed physician (preferably by a board certified neurologist). A deficit in intellectual ability need not be present, but condition must result in a substantial disability that is likely to continue indefinitely and affects the person's ability to function normally in society, as evidenced by

- a) if less than 7 years old, an ICAP Developmental Quotient (Age Equivalent/Chronological Age) of 50 or less,
- b) if 7-17 years old, an ICAP Service Score of 70 or less, or
- c) if age 18 or older, ICAP Broad Independence Domain Score of 514 or less.

☐ Autism:

As diagnosed by a mental health professional clinician (as defined in 7 AAC43.1990 (46)) with the condition meeting the criteria for *DSM-IV code 299.00 Autistic disorder*: when an individual displays 6 or more of 12 symptoms listed across three major areas including social interaction, communication, and behavior. The autism disorder must be manifested prior to the age of 22 and must constitute a substantial disability to the individual's ability to function in society, as evidenced by:

- a) if less than 7 years old, an ICAP Developmental Quotient (Age Equivalent/Chronological Age) of 50 or less,
- b) if 7-17 years old, an ICAP Service Score of 70 or less, or
- c) if age 18 or older, ICAP Broad Independence Domain Score of 514 or less.

☐ **The ICAP assessment document has been signed, dated, and is attached to this LOC document.**

The recommendation for ICF/MR Level of Care is based on input from an interdisciplinary team) consisting of:

☐ **Recipient** **AND** ☐ **Family / guardian for other representative (unless consumer is own guardian)**

And a:

☐ **Qualified Mental Retardation Professional** (*42 CFR483.430* and minimum qualifications standards for DMHDD QMRP staff):

Minimum qualifications for a QMRP are: Master's degree or the equivalent from an accredited college in mental retardation, developmental disabilities, psychology, social work, rehabilitation, nursing or a closely related field, and one year of entry level professional experience monitoring and planning client assessments, treatment or training services for persons experiencing developmental disabilities. Or: A bachelor's degree from an accredited college in mental retardation, developmental disabilities, psychology, social work, rehabilitation, nursing or a closely related field, and one additional year of additional professional level experience in mental retardation, developmental disabilities, psychology, social work, rehabilitation, or a closely related field may substitute for the required master's degree. Or: a doctoral degree from an accredited college in a related field will substitute for one year of required experience. (State of Alaska DD Program Specialist I Job specifications)

☐ **Other professionals involved in recipient's care (list name, reason for participation, credentials and agency affiliation below):**

ICAP Evaluator

Date

I hereby certify that this individual qualifies for ICF/MR Level of Care as defined by reference in (*7 AAC 43.310*). In addition, I certify the individual requires a continuous active treatment program as defined in (*42CFR483.440(a)*) , which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

1. The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible.
2. The prevention or deceleration of regression or loss of current optimal functional status.

But for the provision of waiver services, this consumer would meet admission criteria of an ICF/MR

☐ ICF/MR LOC approved ☐ ICF/MR LOC not approved

DMHDD Developmental Disabilities Program Specialist/QMRP

Date

By federal regulation (*42 CFR441.302 (c)*) Level of Care determinations must be reviewed annually.

If you disagree with the ICF/MR level of care decision you may request a fair hearing under 7 AAC 43.49.

You may request a fair hearing by mail, phone or in person by contacting your Eligibility Technician at the Division of Public Assistance.

If you don't know who your Eligibility Technician is, please call the Division of Public Assistance LTC coordinator at 269-7880.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Division of Mental Health and Developmental Disabilities

MRDD Waiver CLIENT CHOICE OF SERVICES

Name	Care Coordinator
Address	Care Coordination Agency
Social Security/Medicaid #	Requested Services Start Date

This form is to be filled out after the Comprehensive Planning team has completed the Plan of Care. Having a completed or approved Plan of Care does not guarantee eligibility for Medicaid Services. HCB Waiver applicants must continue to meet Division of Public Assistance annual eligibility requirements. In addition, certified and enrolled providers must be available to provide services before services can be authorized

I have gone through the Developmental Disabilities Eligibility Process with DMHDD and have been given a Care Coordination assignment number (CCAN) to be assessed for Medicaid Waiver eligibility. A Comprehensive Planning Team, which I or my representative participated in, has completed a Plan of Care that has been presented to me. *(Please check each box as you read and understand the statement.)*

I understand that:

- ☐ This is an application to find out if Medicaid will pay the cost of my long-term care services.
- ☐ If I am found eligible, and if services are available to me in my community, I may choose to receive care in
1. An ICFMR institution; OR
 2. Receive Medicaid Waiver Home and Community Based Services in my home and in my community as written in my Plan of Care; OR
 3. Receive Community Services only (including the services I may be receiving now); OR
 4. I may choose to have no Medicaid or Community services at all.
- ☐ If I choose to receive institutional care in an ICFMR facility, the care coordinator named above will help me select a facility to meet my needs.
- ☐ If I choose to request the home and community-based services described in the attached Plan of Care, the DMHDD staff will review my case to see if I meet the Level of Care eligibility requirements and they will evaluate the services requested to be sure they are appropriate and are available in my community.

- ☐ If I choose to have no Medicaid HCB Waiver Services but do want to have Community services that are available where I live, my Care Coordinator, DMHDD Grantee Agency or DMHDD staff will assist me to find participating agencies.
- ☐ I have the right to consult with whomever I choose before making this decision, including friends, relatives and advocacy organizations, and that I may authorize any of these people to contact the care coordinator or DMHDD Staff to provide information in helping make this decision.
- ☐ If I choose home and community-based services but am denied because services are not available, I may still be eligible for care in an ICFMR facility.
- ☐ I will receive written notice and an explanation of my appeal rights as presented in 7 AAC 49, if for any reason, I am
1. Found to be ineligible for Medicaid, or
 2. Found to be ineligible for Medicaid Waivers, or
 3. Denied my choice of services or service providers, or
 4. Denied my choice between HCB or Institutional Care.

- ☐ I wish to receive the services described in the attached Plan of Care rather than in an institutional facility. I will receive a copy of my Plan of Care and a cost sheet with approved services after it has been approved by DMHDD. This will be given to me by my Care Coordinator.
- ☐ I do not wish to receive the services described in the attached Plan of Care, and request care in an ICFMR facility.
- ☐ I do not wish to receive the services described in the attached Plan of Care request but do wish to access DMHDD CORE services, which are limited to \$3450 annually. If this is my choice I will receive a list of services available in my community from my Care Coordinator.
- ☐ I do not wish to receive any of the services described in the attached Plan of Care.
- If I change my mind I will contact the care coordinator or DMHDD to request services.

Client's Signature

Date

OR Legal Representative's Signature (Relationship)

Date

**Division of Mental Health and Developmental Disabilities
Waiver Program
Notices of Action, Appeals and Hearings**

Introduction

Alaska's Administrative Code (7 AAC 49) provides applicants for, and recipients of Medicaid waiver services, the right to:

- 1) Notice of adverse actions
- 2) An appeal of such adverse actions
- 3) A fair hearing

Specifically, 7 AAC 49 states that an opportunity for a hearing must be granted to any client whose request for an application is denied, whose claim to Medicaid services is denied or not acted upon with reasonable promptness, or whose benefits the division plans to modify or terminate.

Clients in process under the Waiver program, managed by the Division of Mental Health and Developmental Disabilities (DMHDD), may experience lengthy processing time, denied level of care that results in denial of Medicaid waiver services, or have services or providers changed, modified or denied. They may also receive denials of Medicaid benefits from the Division of Public Assistance (DPA).

Notice of Adverse Action

DMHDD and DPA have the responsibility to provide clients with timely written notice of intent to take action denying, suspending, reducing or terminating assistance. Such notices must include the basis (statute, regulation, and policy) for such action and notify the client of his/her right to a hearing. Care coordinators are sent copies of such notices.

Care Coordinators as Client Advocates

Care coordinators have a responsibility to serve as client advocates. In the event of a grievance, care coordinators are expected to offer assistance to the client throughout the process and/or to refer the client to appropriate sources of assistance.

The Formal Hearing Request

A request for a hearing may be made orally or in writing by the client, or by the client's representative, within 30 days of receiving a notice from DMHDD or DPA of intended action. The request can be made to any employee of the Division of Mental Health and Developmental Disabilities or to the client's eligibility technician or other staff in the Division of Public Assistance.

Requests for hearings are forwarded to the Division of Medical Assistance (DMA) which has the responsibility for conducting fair hearings involving Medicaid issues. No later than 15 days after the receipt of a request, DMA will schedule a hearing and notify the client in writing of the time, date and place of the hearing.

Client Assistance

Upon oral or written request from the client, DMA will provide assistance to the client in obtaining representation, preparing his/her case, and gathering witnesses and/or documents to be used in presenting his/her claim. The client may choose to represent him/herself or have a representative such as a care coordinator, guardian, attorney, friend or family member may be the client representative at the fair hearing.

Fair Hearing

DMA's hearing officer will preside over the proceeding, listen to statements, review records/documents and render a decision no later than 90 days after the receipt by the division of the request for a hearing. The hearing officer will provide the decision to the client in writing. Information will be included to inform the client of his/her right to appeal the hearing officer's decision to the Director, Division of Medical Assistance.

DMA Director's Review

The client must submit his/her appeal of the decision of the DMA hearing officer to the DMA Director within 15 days of receipt of the hearing officer's written decision. Appeal to the DMA Director constitutes the final administrative action available to a client.

The DMA Director must review the record of the hearing, the hearing officer's decision, and applicable laws, regulations, and policies, and render a written decision. This review must be completed no later than 10 days after receiving a client's request for review. The DMA Directors' decision will be sent to the client in writing and will include a statement of the client's right to judicial review.

APPENDIX E - PLAN OF CARE**APPENDIX E-1****a. PLAN OF CARE DEVELOPMENT**

1. The following individuals are responsible for the preparation of the plans of care:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or vocational nurse, acting within the scope of practice under State law

_____ Physician (M.D. or D.O.) licensed to practice in the State

_____ Social Worker (qualifications attached to this Appendix)

 X Case Manager

 X Other (specify): DMHDD QMRP staff who meet care coordination standards may elect to perform this service under 7 AAC 43.1040 (f)

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

 X By case managers

 X By the agency specified in Appendix A

_____ By consumers

_____ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

_____ Every 6 months

 X Every 12 months

_____ Other (specify):

APPENDIX E-2**a. MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Following the information gathering phase, which has included the consumer, family, and multidisciplinary team, the qualified Care Coordinator or qualified DMHDD QMRP staff prepares a Plan of Care. DMHDD staff QMRP approves by signing the completed and agreed upon plan of care.

Final approval of waiver applicants is based on the following:

- 1) the client meets eligibility requirements for HCB Waiver Medicaid;
- 2) the client meets the level of care requirement;
- 3) there is space available on the MRDD waiver;
- 4) there are qualified Providers with the capacity to accommodate the level of services approved on the consumer's POC and also meet health and safety requirements;
- 5) the level of care determination and the plan of care have been adequately documented and approved.

Final approval of waiver applicants does not occur until all determinations have been completed and are approved by a DMHDD-QMRP. The Division of Medical Assistance retains the final review and approval authority for all aspects of the HCB Waivers.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Alaska MRDD Plan of Care

<u>Section I Personal Information:</u>				<i>Plan of Care Start Date:</i>	
				<i>Plan of Care End Date:</i>	
Last Name:		First Name:		Legal Name if Different:	
Male <input type="checkbox"/>		Female <input type="checkbox"/>		Married <input type="checkbox"/>	
Single <input type="checkbox"/>					
Hair Color:		Eye Color:		Height:	
Weight:					
Ethnicity:		Primary Language:		Primary means of communication:	
DOB:		Medicaid #: 06		Is this a Transition Plan?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
SSN:		CCAN Number:			
Other Insurance of Health Care Service		No <input type="checkbox"/>		Yes <input type="checkbox"/> If yes name/number:	
<i>Individual's Physical Address:</i>					
City:		State:		Zip:	
Phone Number:			Email Address:		
Mailing Address:					
City:		State:		Zip:	
<i>School Name:</i>				Phone Number:	
School Address:			City:		State:
Zip:					
Contact Name:					
Place of Employment:				Phone Number:	
Contact Name:					
Employment Address:			City:		State:
Zip:					
<i>Legal Representative:</i>				Role/Relationship:	
Mailing Address:					
City:		State:		Zip:	
Work Phone Number:			Pager or Cell Phone Number:		
Home Phone Number:			Email Address:		
<i>Emergency Contact:</i>				Role/Relationship:	
Work Phone Number:			Home Phone Number:		
Email Address:					
Address:					
City:		State:		Zip:	
<i>DMHDD Agency Providing Services:</i>				Agency Contact:	
Address:			Phone Number:		
City:		State:		Zip:	
Email Address:					
<i>HCB Waiver Care Coordination Agency:</i>				CMG#	
Care Coordinator:				CM#	
Address:					
City:		State:		Zip:	
Phone Number:			Cell Phone Number:		

Section II Diagnosis:

List primary diagnosis (qualifying diagnosis for MRDD Waiver) : _____

Secondary diagnosis/conditions that have lasted longer than 30 days in the previous 12 months.:

Adaptive Equipment: List adaptive equipment that is currently in use, and that which is needed now and/or within the next year.

Medications: List Medications taken at the start date of the plan of care, means of administering each medication and the level of assistance needed to help the individual take medications:

List of Medications	Dosage	Means of administering	Reasons for taking	Level of assistance needed

Section III . A personal shapshot: Please write a summary of the individual including a typical day, favorite activities, strengths, religious affiliations, family relationships, sports, desires, etc. Please describe the following skills identified in the ICAP domains as they are used by the individual in his or her daily life: Motor skills, Social and Communication skills, Personal Living skills, Community living skills, and Behaviors that require intervention by others. This description will support and be linked to the individual's services and goals as outlined in sections IV and V.

Section IV Summary of Services: List services that will meet the needs of the individual as identified in Section III. Include all types of services this person requires including those provided by grantee services, profit and not for profit community programs, HCB Waiver services, Medicaid, family supports and any other individuals or programs that provide supports, whether service is donated or paid for as an HCB Waiver service. Each ICAP domain area listed in Section III: Motor skills, Social and Communication skills, Personal Living skills, Community living skills, and Behaviors requires supports for this person to meet his or her health and safety needs. Please list the provider of service, type of service, how often it occurs, and how long the service is, that supports the individual in obtaining these needs.

Example			
<i>Type of Service</i>	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>
Description of services to be provided that will meet consumer needs and goals: (What does the person do and learn with this service)			

HCB Waiver Services	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

HCB Waiver Services	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

HCB Waiver Services	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

HCB Waiver Services	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Regular Medicaid	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Regular Medicaid	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Regular Medicaid	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

DMHDD Grant Services	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

DMHDD Grant Services	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Community Programs	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Community Programs	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Community Programs	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Community Programs	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Family Supports	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Family Supports	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Other	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Other	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Other	<i>Provider of service</i>	<i>How often</i>	<i>How Long</i>

Description of services to be provided that will meet consumer needs and goals:

Section V: *Goals and Objectives*

The completed Plan of Care should clearly and concisely communicate the strengths, needs, desires and plans for an individual in such a manner that a new provider could pick up the document and use it as a working tool to provide services. The Plan of Care is meant to be inclusive.

The needs identified in section III & IV, which the planning team identifies as requiring specific learning objectives, will be described through the goals and objectives in Section V. The individual's attainment of these goals will be accomplished through HCB Waiver services. Other supports that assist will be listed in Section IV.

All goals and objectives must be measurable. Use additional pages as necessary.

I. Goal :

Individual's need or desire addressed with this goal:

Objective(s) related to this goal:

Service to be provided that will address this goal:

Frequency and duration of service:

Position that does teaching/training:

How objective will be measured:

II. Goal :

Individual's need or desire addressed with this goal:

Objective(s) related to this goal:

Service to be provided that will address this goal:

Frequency and duration of service:

Position that does teaching/training:

How objective will be measured:

Section VI Consumer Choice :

Please read, and if in agreement read, initial each statement and/or check the box :

This Individualized Habilitation Plan of Care has been carefully planned and coordinated with the active involvement of the person served. The plan is individually tailored, and establishes goals and objectives that incorporate the unique needs and preferences of the person served. Necessary personnel and the person served should be involved in the plan's development and the evaluation of its continuing appropriateness.

It has been explained that the intended purpose of this plan is to help me/my child to maximize my/their independence and lead a fulfilling lives. I, or any member of my team, may request another meeting at any time during the next 12 months to make major changes to this plan.

Finally, it has been explained that each member of my program planning team will receive a copy of the final Plan of Care. Unless otherwise stated, I am in agreement with this Plan of Care.

- ☐ I have participated in the planning of my own care and agree with my plan of care.
- ☐ I have the right to self-determination, including participation in developing my own plan of care.
- ☐ I have the right to privacy and confidentiality.
- ☐ I have the right to be given a fair and comprehensive assessment of my health and functional, psychosocial and cognitive abilities.
- ☐ I have the right to access health and social services offered under Alaska's Medicaid State Plan though my options may be limited based on the geographic location of the community in which I live and enrolled service providers.
- ☐ I have the right to know the cost of service before receiving care.
- ☐ I have the right to be notified in writing of any change in services, termination of services, or discharge from waiver services, including the right to appeal any decision.(See following page of this document)
- ☐ I have the right to refuse any portion of the plan of care.
- ☐ I have the right to change service providers, including my care coordinator, at any time.
- ☐ I have the right to withdraw from the waiver application process at any time.
- ☐ In the event I feel my rights have been violated or I have been treated improperly I have been given a phone number to call and understand I have the right to a grievance procedure.
- ☐ All of the options available in my community of choice have been fully explained to me.

I choose to receive:

- | | |
|--|--|
| <input type="checkbox"/> Waiver and community services, or | <input type="checkbox"/> Services in an institution (ICF/MR), or |
| <input type="checkbox"/> Community services only, or | <input type="checkbox"/> No state coordinated services at all. |

Individual's Signature	Date	Parent or Legal Representative	Date
Care Coordinator Signature	Date	DD Grantee Agency Representative	Date
HCB Agency Representative	Date	HCB Agency Representative	Date
HCB Agency Representative	Date	HCB Agency Representative	Date

I have reviewed this Plan of Care and approve the services as noted.

DMHDD Regional Program Specialist QMRP Date	DMHDD Administrator/ QMRP	Date
---	---------------------------	------

Division of Mental Health and Developmental Disabilities Waiver Program Notices of Action, Appeals and Hearings

Introduction

Alaska's Administrative Code (7 AAC 49) provides applicants for, and recipients of Medicaid waiver services, the right to:

- 1) Notice of adverse actions
- 2) An appeal of such adverse actions
- 3) A fair hearing

Specifically, 7 AAC 49 states that an opportunity for a hearing must be granted to any individual whose request for an application is denied, whose claim to Medicaid services is denied or not acted upon with reasonable promptness, or whose benefits the division plans to modify or terminate.

Individuals in process under the Waiver program, managed by the Division of Mental Health and Developmental Disabilities (DMHDD), may experience lengthy processing time, denied level of care that results in denial of Medicaid waiver services, or have services or providers changed, modified or denied. They may also receive denials of Medicaid benefits from the Division of Public Assistance (DPA).

Notice of Adverse Action

DMHDD and DPA have the responsibility to provide individuals with timely written notice of intent to take action denying, suspending, reducing or terminating assistance. Such notices must include the basis (statute, regulation, and policy) for such action and notify the individual of his/her right to a hearing. Care coordinators are sent copies of such notices.

Care Coordinators as Individual Advocates

Care coordinators have a responsibility to serve as individual advocates. In the event of a grievance, care coordinators are expected to offer assistance to the individual throughout the process and/or to refer the individual to appropriate sources of assistance.

The Formal Hearing Request

A request for a hearing may be made orally or in writing by the individual, or by the individual's representative, within 30 days of receiving a notice from DMHDD or DPA of intended action. The request can be made to any employee of the Division of Mental Health and Developmental Disabilities or to the individual's eligibility technician or other staff in the Division of Public Assistance. Requests for hearings are forwarded to the Division of Medical Assistance (DMA) which has the responsibility for conducting fair hearings involving Medicaid issues. No later than 15 days after the receipt of a request, DMA will schedule a hearing and notify the individual in writing of the time, date and place of the hearing.

Individual Assistance

Upon oral or written request from the individual, DMA will provide assistance to the individual in obtaining representation, preparing his/her case, and gathering witnesses and/or documents to be used in presenting his/her claim. The individual may choose to represent him/herself or have a representative such as a care coordinator, guardian, attorney, friend or family member may be the individual representative at the fair hearing.

Fair Hearing

DMA's hearing officer will preside over the proceeding, listen to statements, review records/documents and render a decision no later than 90 days after the receipt by the division of the request for a hearing. The hearing officer will provide the decision to the individual in writing. Information will be included to inform the individual of his/her right to appeal the hearing officer's decision to the Director, Division of Medical Assistance.

DMA Director's Review

The individual must submit his/her appeal of the decision of the DMA hearing officer to the DMA Director within 15 days of receipt of the hearing officer's written decision. Appeal to the DMA Director constitutes the final administrative action available to a individual. The DMA Director must review the record of the hearing, the hearing officer's decision, and applicable laws, regulations, and policies, and render a written decision. This review must be completed no later than 10 days after receiving a individual's request for review. The DMA Directors' decision will be sent to the individual in writing and will include a statement of the individual's right to judicial review.

MRDD Waiver **INDIVIDUAL CHOICE OF SERVICES**

Name	Care Coordinator
Address	Care Coordination Agency
Social Security/Medicaid #	Requested Services Start Date

This form is to be filled out after the Comprehensive Planning team has completed the Plan of Care. Having a completed or approved Plan of Care does not guarantee eligibility for Medicaid Services. HCB Waiver applicants must continue to meet Division of Public Assistance annual eligibility requirements. In addition, certified and enrolled providers must be available to provide services before services can be authorized

I have gone through the Developmental Disabilities Eligibility Process with DMHDD and have been given a Care Coordination assignment number (CCAN) to be assessed for Medicaid Waiver eligibility. A Comprehensive Planning Team, which I or my representative participated in, has completed a Plan of Care that has been presented to me. *(Please check each box as you read and understand the statement.)*

I understand that:

- ☐ This is an application to find out if Medicaid will pay the cost of my long-term care services.
- ☐ If I am found eligible, and if services are available to me in my community, I may choose to receive care in
 1. An ICFMR institution; OR
 2. Receive Medicaid Waiver Home and Community Based Services in my home and in my community as written in my Plan of Care; OR
 3. Receive Community Services only (including the services I may be receiving now); OR
 4. I may choose to have no Medicaid or Community services at all.
- ☐ If I choose to receive institutional care in an ICFMR facility, the care coordinator named above will help me select a facility to meet my needs.
- ☐ If I choose to request the home and community-based services described in the attached Plan of Care, the DMHDD staff will review my case to see if I meet the Level of Care eligibility requirements and they will evaluate the services requested to be sure they are appropriate and are available in my community.
- ☐ If I choose to have no Medicaid HCB Waiver Services but do want to have Community services that are available where I live, my Care Coordinator, DMHDD Grantee Agency or DMHDD staff will assist me to find participating agencies.
- ☐ I have the right to consult with whomever I choose before making this decision, including friends, relatives and advocacy organizations, and that I may authorize any of these people to contact the care coordinator or DMHDD Staff to provide information in helping make this decision.

- ☐ If I choose home and community-based services but am denied because services are not available, I may still be eligible for care in an ICFMR facility.
- ☐ I will receive written notice and an explanation of my appeal rights as presented in 7 AAC 49, if for any reason, I am
5. Found to be ineligible for Medicaid, or
 6. Found to be ineligible for Medicaid Waivers, or
 7. Denied my choice of services or service providers, or
 8. Denied my choice between HCB or Institutional Care.

- ☐ I wish to receive the services described in the attached Plan of Care rather than in an institutional facility. I will receive a copy of my Plan of Care and a cost sheet with approved services after it has been approved by DMHDD. This will be given to me by my Care Coordinator.
- ☐ I do not wish to receive the services described in the attached Plan of Care, and request care in an ICFMR facility.
- ☐ I do not wish to receive the services described in the attached Plan of Care request but do wish to access DMHDD CORE services, which are limited to \$3450 annually. If this is my choice I will receive a list of services available in my community from my Care Coordinator.
- ☐ I do not wish to receive any of the services described in the attached Plan of Care.
- If I change my mind I will contact the care coordinator or DMHDD to request services.

Individual's Signature	Date
OR Legal Representative's Signature (Relationship)	Date

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):

 X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

 Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

 Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

 Other (Describe in detail):

b. BILLING PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
 - a. When the individual was eligible for Medicaid waiver payment on the date of service;
 - b. When the service was included in the approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

 X Yes

 No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

 X All claims are processed through an approved MMIS.

 MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

 The Medicaid agency will make payments directly to providers of waiver services.

 X The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

 The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

 Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	PEOPLE	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
YR1	960	\$ 64,364	\$ 11,244	\$ 175,183	\$ 11,961
YR2	1008	\$ 65,687	\$ 11,492	\$ 179,037	\$ 12,224
YR3	1059	\$ 66,986	\$ 11,745	\$ 182,976	\$ 12,493
YR4	1112	\$ 68,319	\$ 12,003	\$ 187,001	\$ 12,768
YR5	1,168	\$ 69,655	\$ 12,267	\$ 191,115	\$ 13,049

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR UNDUPLICATED INDIVIDUALS

1 960 2 1008 3 1059 4 1112 5 1168

EXPLANATION OF FACTOR C:

Check one:

 X The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

 The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following pages.

Factor D is based on the estimated value for ICFMR Level of Care in FY01, and incorporating the annual MCPI inflation factor of 2.2%.

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Residential habilitation, day habilitation, intensive active treatment/therapies, care coordination, meals, supported employment and chore services may be given at assisted living homes or residential supported living facilities. Foster home or assisted living home providers document billing recipient, family or other source for the cost of basic board and room which is not reimbursable by Medicaid.

When developing payment rates for above services, room and board components are excluded. Client room and board costs are specifically noted on cost sheet, and are the responsibility of the qualified provider to collect.

Meals reimbursed through the HCB Waivers shall not constitute a full day's regimen and will be limited to 1 or 2 meals per day.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Residential habilitation, day habilitation, intensive active treatment/therapies, care coordination, meals.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

When developing payment rates for above services, room and board components are excluded. Client room and board costs are specifically noted on cost sheet, and are the responsibility of the qualified provider to collect.

Meals reimbursed through the HCB Waivers shall not constitute a full day's regimen and will be limited to 1 or 2 meals per day.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

 X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

 The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

- ☐ Based on HCFA Form 2082 (relevant pages attached).
- ☐ Based on HCFA Form 372 for years ____ of waiver # ____, which serves a similar target population.
- ☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- ☒ Other (specify):

Factor D' is based on data from HCFA Form 372 reports, MMIS statistically valid data from FY98-FY01, as well as an allowance for expected growth in service delivery and a 2.2% inflation factor based on the the Anchorage Medical Consumer Price Index (MCPI).

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- ☐ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- ☒ Based on trends shown by HCFA Form 372 for prior years of waiver #0260, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.
- ☐ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- ☐ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- ☐ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

☐ Based on HCFA Form 2082 (relevant pages attached).

☒ Based on HCFA Form 372 for prior years of waiver # 0260, which serves a similar target population.

Factor G' is based on data from HCFA Form 372 reports, MMIS statistically valid data from FY98-FY01, as well as an allowance for expected growth in service delivery and a 2.2% inflation factor based on the the Anchorage Medical Consumer Price Index (MCPI).

☐ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

☐ Other (specify):

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

Year 1

Factor D	\$	64,364	Factor G	\$	175,183
Factor D'	\$	11,244	Factor G'	\$	11,961
Total D value	\$	75,608	<Total G value	\$	187,144

Year 2

Factor D	\$	65,687	Factor G	\$	179,037
Factor D'	\$	11,492	Factor G'	\$	12,224
Total D value	\$	77,179	<Total G value	\$	191,261

Year 3

Factor D	\$	66,986	Factor G	\$	182,976
Factor D'	\$	11,745	Factor G'	\$	12,493
Total D value	\$	78,731	<Total G value	\$	195,469

Year 4

Factor D	\$	68,319	Factor G	\$	187,001
Factor D'	\$	12,003	Factor G'	\$	12,768
Total D value	\$	80,322	<Total G value	\$	199,769

Year 5

Factor D	\$	69,655	Factor G	\$	191,115
Factor D'	\$	12,267	Factor G'	\$	13,049
Total D value	\$	81,922	<Total G value	\$	204,164